

MULTI-DISCIPLINARY PATIENT EDUCATION DOCUMENTATION RECORD

LEARNING READINESS ASSESSMENT:

- | | |
|---|--|
| <input type="checkbox"/> Adult | <input type="checkbox"/> Pt motivated/ready to learn |
| <input type="checkbox"/> Adolescent (12-18) | <input type="checkbox"/> Family/SO motivated/ready to learn |
| <input type="checkbox"/> Child/Infant | <input type="checkbox"/> School-aged pts given opportunity to continue schooling |

IDENTIFY BARRIERS TO LEARNING:

- | | |
|--|-------|
| <input type="checkbox"/> physical/cognitive: | _____ |
| <input type="checkbox"/> language: | _____ |
| <input type="checkbox"/> cultural/religious: | _____ |
| <input type="checkbox"/> emotional/motivational: | _____ |
| <input type="checkbox"/> none | |

MEDICATION TEACHING: Patient has been instructed on the purpose, dose, frequency, potential/likely side effect or other considerations during use, and relevant nutrient-drug-supplement interactions for the following meds:

<u>Med</u>	<u>Date/Initials</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL EQUIPMENT: Use, purpose, meaning of alarms, persons authorized to manage controls, methods of safe patient interaction, outcomes of improper use (as appropriate) for the following

<u>Date/Initials</u>		<u>Date/Initials</u>	
_____	Intravenous infusion pump	_____	Cryocuff
_____	PCA pump	_____	Pulse oximetry
_____	Incentive spirometer	_____	Oxygen equipment
_____	Continuous passive motion machine (CPM)	_____	Other (specify):
_____	Sequential compression device (SCD)	_____	_____
_____	HP monitor/telemetry	_____	_____

SPECIAL DIETS (those likely to require patient management or a duration of > 24 hrs):

<u>Date/Initials</u>		<u>Date/Initials</u>	
_____	Cardiac	_____	Other: _____
_____	Diabetic	_____	Other: _____

Addressograph:

REFERRALS/CONSULTS:

<input type="checkbox"/> Mental Health	Date/Initials: _____
<input type="checkbox"/> Patient Education	Date/Initials: _____
<input type="checkbox"/> Dietician	Date/Initials: _____
<input type="checkbox"/> New Parent Support	Date/Initials: _____
<input type="checkbox"/> Maternal Support Services	Date/Initials: _____
<input type="checkbox"/> Resolve Through Sharing	Date/Initials: _____
<input type="checkbox"/> Other: _____	Date/Initials: _____
<input type="checkbox"/> Other: _____	Date/Initials: _____

PRE-OP, POST-OP, AND OTHER PROCEDURES TEACHING:

Labs, X-Ray, EKG	Date/Initials: _____	Comments: _____
Operating Room	Date/Initials: _____	Comments: _____
Anesthesia	Date/Initials: _____	Comments: _____
Recovery Room	Date/Initials: _____	Comments: _____
Dressing/Incision	Date/Initials: _____	Comments: _____
Drains	Date/Initials: _____	Comments: _____
Ambulation	Date/Initials: _____	Comments: _____
Hygiene/Grooming	Date/Initials: _____	Comments: _____
Bowel/Bladder	Date/Initials: _____	Comments: _____
Breathing Exercises	Date/Initials: _____	Comments: _____
Discharge Criteria	Date/Initials: _____	Comments: _____

PHYSICAL THERAPY TEACHING:

Shoulder Immobilizer	Date/Initials: _____	Comments: _____
Sling	Date/Initials: _____	Comments: _____
Crutches	Date/Initials: _____	Comments: _____
Brace	Date/Initials: _____	Comments: _____
Exercises	Date/Initials: _____	Comments: _____

Other _____

_____**Initials/ Signature**

_____**Addressograph:**